LifeBack
Get Yours.

4 Princess Road • Lawrenceville, NJ 08648
Phone: (609) 482-3701 • Fax: (609) 482-3702

Consent for Release of Confidential Information

I, _____, whose date of birth is _____

authorize LifeBack to disclose to and/or obtain from: _____

_____

the following information: (patient should initial each item to be disclosed)

(PA Request can ONLY be obtain from OR release to, can not combine on one form)

_____ Counseling Assesment
_____Diagnosis
_____ Psychiatric Evaluation
_____ Treatment Plan or Treatment Summary
_____ Medication Management Information
_____Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____Continuum of Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes *(cannot be combined with any other disclosure)*
_____Other (indicate below)

Purpose: The purpose for this disclosure of information is to:
Coordinate care with other treatment provider(s) [ ]
Satisfy legal requirements [ ]
Satisfy employment requirements [ ]
Satisfy school requirements [ ]
Other [ ] Specify:
_____
_____

Revocation: I understand that I have a right to revoke this authorization at any time by providing written notification to the Clinical Director of LifeBack. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

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Expiration: Unless sooner revoked, this authorization expires on (can not be more than 1 year)
_____

Conditions: I further understand that LifeBack will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, LifeBack reserves the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law including, but not limited to, verbally, in paper format, or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections. Federal law 42 C.F.R. Part 2 prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R Part 2.

I will be given a copy of this authorization for my records.

_____

Signature of Patient Date:

_____

Signature of Witness Date:

_____

Signature of Parent, Guardian, or Personal Representative Date:

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate or other legally authorized person):

_____